MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (59)

10846

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): one day

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: City

City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 2346 W. Lexington Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Christine Ackerman

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6 (b) Name of husband or wife: Edward Ackerman

deceased 6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 10, 1879

8. AGE: Years	Months	Days	If less than one day
60		11	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Belt-maker

11. Industry or business:

FATHER 12. Name: Frederick Schmidt

13. Birthplace: Germany

MOTHER 14. Maiden name: Laura Bitowski

15. Birthplace: Germany

16. Informant: Hospital records

Address: Sykesville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 24 1939 (month) (day) (year)

Cemetery or crematory: Taylor Park Cemetery

Location: Frederick Ave.

18. Funeral director: Wm Cook

Address: 1217 St Paul St Balto Md

19. 11/21/39 (Date rec'd by registrar) Harry Wells Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 21 1939, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 20 1939, to Nov 21 1939, and that I last saw her alive on Nov 21 1939.

Immediate cause of death: Cerebral Hemorrhage — DURATION: Nov 17, '39

Due to: Arteriosclerosis, Diabetes Mellitus — DURATION: Known since Nov 20, 1939

Due to:

Other conditions: Hypostatic pneumonia, Myocardia degeneration
(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Ruth M. Williams, M. D.
M. D. or other

Address: Sykesville, Md. Date signed 11-21-39

RECEIVED
NOV 28 1939
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-C)

CERTIFICATE OF DEATH

10847

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital
Stay in hospital or inst. (yrs., or mos., or days): 16 days
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 3501 Parkside Drive
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Henry G. Altevogt

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	

6 (b) Name of husband or wife: Unknown
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 27 - 1860

8. AGE:

Years	Months	Days	If less than one day
79	5	19	hrs. min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
FATHER 12. Name: Frederick Altevogt
13. Birthplace: Germany
MOTHER 14. Maiden name: — Dolber
15. Birthplace: Germany
16. Informant: Hospital Records
Address: Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 17 1939 (month) (day) (year)
Cemetery or crematory: Oak Lawn Cemetery
Location: Baltimore Md.
18. Funeral director: John Ulrich
Address: 1008 Orleans St. Balto.
19. Nov 15 1939 (Date rec'd by registrar) C. Harry Heer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 15 1939, at 2:35 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 30 1939 to November 15 1939, and that I last saw h in alive on November 15 1939.

	CURATION
Immediate cause of death: Chronic Myocarditis and Myocardial Degeneration	Known Oct. 31-39
Due to: Arteriosclerosis	1935
Due to:	
Other conditions: Senile Psychosis	1935

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. Virginia Beyer M.D. (M. D. or other)
Address: Sykesville, Md. Date signed 11-15-39

RECEIVED
NOV 20 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-C)

CERTIFICATE OF DEATH

10848

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 8 months, 27 days

Stay in this community (yrs., or mos., or days): 8 months, 27days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore (City)

City or town: Baltimore Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 3912 Southern Ave. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Margaret Auck

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: Christian J. Auck

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 20, 1865

8. AGE: Years	Months	Days	If less than one day
74	7	9	hrs. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: ? Werner; 13. Birthplace: Germany

MOTHER — 14. Maiden name: Unknown; 15. Birthplace: Germany

16. Informant: Hospital Records

Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/2/1939 (month) (day) (year)

Cemetery or crematory: Baltimore Cemetery

Location: North Ave & Gay St.

18. Funeral director: Howard N. Blight Jr.

Address: 4914 Belair Road

19. Nov 29 1939 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 29, 1939, at 5:15PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19, 1939 to Nov. 29 1939, and that I last saw her alive on Nov. 29 1939

Immediate cause of death	DURATION
Chronic Myocarditis with Myocardial Degeneration	1 yr.
Due to Generalized Arterio-sclerosis	At least 1 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN — Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: William Schelling M.D. M.D. or other

Address: Springfield State Hosp. Sykesville, Md. Date signed 11/29/39.

RECEIVED
DEC 1 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-C)

10849

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster (Rural near)
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 70 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town rural near Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Vernon H. Barnes

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Grace M. Owings

6(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) September 25, 1869

8. AGE:

Years	Months	Days	If less than one day
70	1	15	hrs. min.

9. Birthplace Westminster, Carroll, Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Alfred H. Barnes
13. Birthplace Maryland

MOTHER
14. Maiden name Susan H. Barnes
15. Birthplace Maryland

16. Informant Mrs. Grace M. Barnes

Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/12/39 (month) (day) (year)

Cemetery or crematory Stone Chapel Cemetery

Location Warfieldsburg, Md.

18. Funeral director J. Francis Reese

Address Westminster, Md.

19. 11/10 1939 H. Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9 1939, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 6 1939, to Nov 9 1939, and that I last saw him alive on November 9 1939.

Immediate cause of death	DURATION
Broncho-Pneumonia	1 da
Due to Hemiplegia - Cerebral Hemorrhage	3 das
Due to Arterio-Sclerosis	?
Chronic Myocarditis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations None

Of autopsy None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE Jas. T. Marsh M. D.

Address New Windsor Md Date signed 11/10/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M) (T)

RECEIVED
DEC 5 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

10850
Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days) 5 yr 8 Mo. 17 Da.
Stay in this community (yrs., or mos., or days) (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County St. Mary's
City or town Ridge, Maryland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Montell Jerome Biscoe

3. (b) Social Security Number

4. Sex: Male
5. Color or race: Colored
6. (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife ---
6(c) If alive, give age --- years
7. Birth date of deceased (mo., day, yr.) Feb. 9, 1914
8. AGE: Years 25 | Months 10 | Days 9 | If less than one day ___ hrs. ___ min.
9. Birthplace Ridge, Maryland (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business ---
FATHER 12. Name Randolph Biscoe
13. Birthplace Ridge, Maryland
MOTHER 14. Maiden name Dora Reid
15. Birthplace Park Hall, Md.
16. Informant Dr. Reuben Hoffman
Address Henryton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 21 1939 (month) (day) (year)
Cemetery or crematory St. Peters Claver's
Location Ridge M.D.
18. Funeral director Smith's Funeral Home
Address 1125-19th St. N.W. D.C.
19. Nov. 19, 1939 (Date rec'd by registrar) 19 Albert R Swankham Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19, 1939 9:10 A.M. 19 ___, at ___ M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 23, 1934 19 ___, to Nov. 19, 1939 19 ___, and that I last saw him alive on Nov. 19, 1939 19 ___.
Immediate cause of death Pulmonary Tuberculosis — DURATION Aug. 1933
Due to ---
Due to ---
Other conditions ---
(Include pregnancy within 3 months of death)
Major findings: ---
Of operations
Of autopsy No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide --- Date of ---
Where did injury occur? --- (City or town) (County) --- (State)
Injured at home, farm, industry, public place (where?)
Means of injury -- Injured at work? --
23. SIGNATURE Reuben Hoffman, M.D. M. D. or other
Address Henryton, Maryland Date signed 11/19/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

RECEIVED
DEC 4 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3)

CERTIFICATE OF DEATH

10851

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster (Rural)
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: New Manchester Rd. Nr. Cranberry
Stay in hospital or Inst. (yrs., or mos., or days) —
Stay in this community (yrs., or mos., or days) — none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural near Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Manchester Rd
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME (No name given baby) Brown

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	S

6 (b) Name of husband or wife —
6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 9, 1939

8. AGE:

Years	Months	Days	If less than one day
0	0	0	0 hrs. 0 min.

9. Birthplace Carroll Co. Md. near Westminster (Town, county, and state)
10. Usual occupation D
11. Industry or business 0
FATHER 12. Name William Frederick Brown
13. Birthplace Carroll Co.
MOTHER 14. Maiden name Viola Haines
15. Birthplace Frederick Co.
16. Informant William Brown
Address Westminster Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 11, 39 (month) (day) (year)
Cemetery or crematory Oakmount
Location Ok Cremmer
18. Funeral director Fatha
Address Westminster
19. 11/10 1939 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9 1939, at 2 3 M

21. I CERTIFY that death occurred on the date above stated; that ~~I attended deceased from~~ deceased was macerated and that I last saw h 7 alive mos 9 stillborne baby

	DURATION
Immediate cause of death Unknown Possible vitamin E deficiency (mother subject to habitual abortion or miscarriage (3 previous ones))	
Due to —	
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE E Reese Wilsons M.D
Address Westminster M. D. or other
Date signed Nov 10 1939

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 5 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

10852

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days) 6 Mos. 22 Days
Stay in this community (yrs., or mos., or days) (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 27 N. Spring St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR --

3. (a) FULL NAME Corrine Gertrude Brown

3. (b) Social Security Number ---

4. Sex: Female
5. Color or race: Colored
6. (a) Single, married, widowed, or divorced: Married
B (b) Name of husband or wife: James Brown
6(c) If alive, give age --- years
7. Birth date of deceased (mo., day, yr.) June 5, 1920
8. AGE: Years 19 | Months 5 | Days 22 | If less than one day ___ hrs. ___ min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business ---
FATHER 12. Name Archie Scott
13. Birthplace Virginia
MOTHER 14. Maiden name Mamie Thomas
15. Birthplace Baltimore, Md.
16. Informant Dr. Reuben Hoffman
Address Henryton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/30/39 (month) (day) (year)
Cemetery or crematory Arbutus
Location Baltimore Co. Md
18. Funeral director Mrs C. H. Baley
Address 4 Jefferson St
19. 11/27/39 (Date rec'd by registrar) 19 Deputy Local Registrar Albert R Swankhaus

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27, 1939 10:00 P.M. 19 , at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5, 1939 19 , to Nov. 27, 1939 19
and that I last saw her alive on Nov. 27, 1939 19
Immediate cause of death Pulmonary Tuberculosis — DURATION Sept. 1938
Due to ---
Due to ---
Other conditions ---
(Include pregnancy within 3 months of death)
Major findings:
Of operations ---
Of autopsy no autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of --
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ---
Means of injury -- Injured at work? --

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other
Address Henryton, Maryland Date signed 11/27/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 30 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

10853

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Henryton (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days) 2 Mos. 3 Days
Stay in this community (yrs., or mos., or days) (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Talbot
City or town McDaniel Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Dorothy Turner Burse

3. (b) Social Security Number ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Daniel Burse
6(c) If alive, give age Unknown years

7. Birth date of deceased (mo., day, yr.) April 22, 1909

8. AGE: Years	Months	Days	If less than one day
20	7	8	---hrs. ---min.

9. Birthplace McDaniel, Md. (Town, county, and state)
10. Usual occupation None
11. Industry or business ---

FATHER
12. Name Albert Turner
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden name Maggie Webb
15. Birthplace McDaniel, Md.

16. Informant Dr. Reuben Hoffman
Address Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 3 - 39 (month) (day) (year)
Cemetery or crematory Claiborne md.
Location Eastern shore
18. Funeral director John F. Mitchell & Sons.
Address 1800 Eutaw Pl. Balto md.

19. 11/30/39 (Date rec'd by registrar) 19 Albert R. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION 12:40 A.M.

20. DATE OF DEATH November 30, 1939 19 , at M

21. I CERTIFY that death occured on the date above stated; that I attended deceased from Sept. 27, 1939 19 to Nov. 30, 1939 19 and that I last saw her alive on Nov. 30, 1939 19

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Aug. 1938
Due to ---	
Due to ---	
Other conditions ---	

(Include pregnancy within 3 months of death)

Major findings:
Of operations ---
Of autopsy No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide --- Date of --
Where did injury occur? --- (City or town) --- (County) (State)
Injured at home, farm, industry, public place (where?) ---
Means of injury --- Injured at work? --

23. SIGNATURE Reuben Hoffman, M.D.
M. D. or other
Address Henryton, Maryland Date signed 11/30/39

RECEIVED
DEC 4 1939
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(957)

Reg. Dist. No. 26 10854

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Wistminster

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Geoze Hut

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Georges

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Annie Caple

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed

6 (b) Name of husband or wife William Caple

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23 1857

8. AGE:

Years	Months	Days	If less than one day
82	7	23	hrs. min.

9. Birthplace Westminster, Carroll, Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER

12. Name Reuben W. Stem

13. Birthplace Maryland

MOTHER

14. Maiden name not known

15. Birthplace

16. Informant Mr Rolf Menkey

Address Westminster, Md.

17. Burial Date thereof Nov. 18-1939
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Ebenezer Cemetery

Location Winfield Carroll Co. Maryland

18. Funeral director H Bankard & Son

Address Westminster, Maryland

19. 11/17 39 L K Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16 1939, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 15 1939 to Nov 16 1939, and that I last saw her alive on Nov 15 1939.

	DURATION
Immediate cause of death Arteria-Sclerotic Cardio Renal disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Glenn Speecher M. D. or other

Address Westminster Date signed Nov 16/39

RECEIVED
DEC 5 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82-a)

10855

CERTIFICATE OF DEATH

Reg. Dist. No. 83

1. PLACE OF DEATH:

County: Carroll

City or town: Woodline, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 17

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Woodline, Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: No.

3. (a) FULL NAME: Harry Harrison Chaney.

3. (b) Social Security Number: No.

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Jan. 10, 1887

8. AGE: Years: 52 Months: 9 Days: 26 If less than one day: hrs. min.

9. Birthplace: Carroll Co. Md.
(Town, county, and state)

10. Usual occupation: Farmer.

11. Industry or business

FATHER
12. Name: Perry L. Chaney.
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Margaret E. Harrison
15. Birthplace: Maryland.

16. Informant: Mr. Perry L. Chaney.
Address: Woodline, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Nov. 9, 1939 (month) (day) (year)

Cemetery or crematory: Morgan Chapel

Location: Day, Carroll Co. Maryland.

18. Funeral director: C. M. Waltz
Address: Winfield, Md

19. Nov 9 1939 Edna M. Hewitt
(Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 6, 1939, at 4:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 5 1939, to Nov 6 1939, and that I last saw him alive on Nov. 6 1939.

Immediate cause of death: Cerebral appoplexy — DURATION: 25 hrs.

Due to: Hypertension — ?

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations: none.
Of autopsy: none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: J. Stanley Grabill M. D. ~~or other~~

Address: Mt Airy, Md Date signed: 11/8/39

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 14 1939

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

10856

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Maryland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 2yrs. 7mos. 16days

Stay in this community (yrs., or mos., or days): More than 5 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Ward No.

(If ontside city or town limits, write RURAL NEAR and give town)

Street No.: 46 Randall Street

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Alma Elizabeth Colfer

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 6- 1919

8. AGE:

Years	Months	Days	If less than one day
20	3	3	hrs. min.

9. Birthplace: Newark, N.J.

(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: William A. Colfer

FATHER — 13. Birthplace: Newark, N.J.

MOTHER — 14. Maiden name: Ethel Colburn

MOTHER — 15. Birthplace: Annapolis, Maryland

16. Informant: Hospital Records

Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 11 1939 (month) (day) (year)

Cemetery or crematory: ROSEHILL CEMETERY

Location: LINDEN N.Y.

18. Funeral director: HENRY F. POWERS

Address: 84 BROAD ST NEWARK N.Y.

19. Nov. 9 1939 (Date rec'd by registrar) C. Harry Keen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 9- 1939, at 7:00 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 16 1939, to November 9 1939, and that I last saw her alive on November 8 1939.

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	May 22, 1939
Due to:	
Due to:	
Other conditions: Epilepsy	19 years

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: M. Virginia Beyer M.D. (M. D. or other)

Address: Sykesville, Md. Date signed: Nov. 9-1939

RECEIVED
NOV 11 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

CERTIFICATE OF DEATH

10857

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 54 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: rural near Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Florence S. Myerly Cook

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6 (b) Name of husband or wife: Calvin E. Cook
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 27, 1867

8. AGE: Years	Months	Days	If less than one day
72	6	14	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Thomas S. Jones
13. Birthplace: Maryland

MOTHER
14. Maiden name: Angeline Sellers
15. Birthplace: Maryland

16. Informant: Mrs. Wilbur Harris
Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 11/13/39 (month) (day) (year)
Cemetery or crematory: Krider's Cemetery
Location: Westminster, Md.

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 11/11 (Date rec'd by registrar) 1939 [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 10, 1939, at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 9, 1939, to Nov 10, 1939, and that I last saw h[illegible] alive on Nov 10, 1939.

Immediate cause of death	DURATION
Acute Cardiac Dilatation	1 day.
Due to Hypertensive Cardio Vascular Disease	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Clifford M. Taylor M.D. M. D. or other
Address: Westminster, Md. Date signed 11-11-39

RECEIVED
DEC 5 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82-a)

CERTIFICATE OF DEATH

10858

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll.
City or town Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital.
Stay in hospital or inst. (yrs., or mos., or days) 4 mos., 12 days.
Stay in this community (yrs., or mos., or days) Same.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland. County Montgomery.
City or town _____ Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)
Street No. _____
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME Frederick A. Coolidge.

3. (b) Social Security Number Unk.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White.	Widowed

6 (b) Name of ~~husband or~~ wife Florence Holbrook.
6(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) August 26, 1877.

8. AGE:

Years	Months	Days	If less than one day
62.	2.	9.	_____ hrs. _____ min.

9. Birthplace Boston, Mass. (Town, county, and state)
10. Usual occupation Naval Draftsman.
11. Industry or business U.S. Navy.

FATHER
12. Name George A. Coolidge.
13. Birthplace Massachusetts.

MOTHER
14. Maiden name Harriet Lincoln.
15. Birthplace Massachusetts.

16. Informant Springfield Hospital Records.
Address Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 7 1939 (month) (day) (year)
Cemetery or crematory Springfield
Location Sykesville Md.

18. Funeral director C. N. Baer
Address Sykesville Md.

19. Nov 4 1939 C. Nancy Baer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4, 1939, at 4 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 23, 1939, to Nov. 4, 1939, and that I last saw him alive on Nov. 4, 1939.

Immediate cause of death	DURATION
Cerebral Haemorrhage	11-4-39.
Due to Cerebral Arterio-sclerosis prior to 6-23-'39.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work?

23. SIGNATURE Harry F. Baer, M.D.
M. D. or other
Address Sykesville, Md. Date signed 11-4-'39.

RECEIVED
DEC 4 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23

CERTIFICATE OF DEATH

10859

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
Stay in hospital or inst. (yrs., or mos., or days) 16 days
Stay in this community (yrs., or mos., or days) (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Somerset
City or town Westover, Route #1 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Dorothy Elizabeth Cottman

3. (b) Social Security Number ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife ---
6(c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) June 24, 1926

8. AGE: Years 13 | Months 4 | Days 16 | If less than one day ---hrs. ---min.

9. Birthplace Westover, Maryland (Town, county, and state)
10. Usual occupation Scholar
11. Industry or business ---

FATHER
12. Name Henry Cottman
13. Birthplace Westover, Md.

MOTHER
14. Maiden name Hattie Schrees
15. Birthplace Westover, Md.

16. Informant Dr. Reuben Hoffman
Address Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 21-1939 (month) (day) (year)
Cemetery or crematory Westover md
Location
18. Funeral director Chas H Ward
Address Marion md

19. Nov. 19, 1939 (Data rec'd by registrar) Albert R Swankhouse Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19, 1939 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 3, 1939 to Nov. 19, 1939
and that I last saw her alive on Nov. 19, 1939

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 1939
Due to --	
Due to ---	
Other conditions ---	

(Includa pregnancy within 3 months of death)

Major findings:
Of operations ---
Of autopsy No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide --- Date of --
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ---
Means of injury -- Injured at work? --

23. SIGNATURE Reuben Hoffman M.D.
M. D. or other
Address Henryton, Maryland Date signed 11/19/3

RECEIVED
DEC 4 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-E)

CERTIFICATE OF DEATH

10860

Reg. Dist. No. 71

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Uniontown

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 14 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County

City or town Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Ulysses Grant Crouse

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widower

B (b) Name of husband or wife S. Burton Bond Crouse

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1866

8. AGE:

Years	Months	Days	If less than one day
73	4	18	hrs. min.

9. Birthplace Carroll (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER

12. Name Samuel J. Crouse

13. Birthplace Md

MOTHER

14. Maiden name Martha Shriner

15. Birthplace Md.

18. Informant G. Paul Crouse

Address Union Bridge, Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 5, 1939 (month) (day) (year)

Cemetery or crematory Lutheran Uniontown, Md.

Location

18. Funeral director C. O. FUSS & SON

Address Taneytown, Md.

19. Nov 5 1939 (Date rec'd by registrar) Margaret R. Englar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3 1939, at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 16 1939, to Nov 1939, and that I last saw him alive on Nov 2 1939.

Immediate cause of death	DURATION
Intestinal Obstruction; due to adhesions following prostatic operation.	
Due to post operative	
not due to cancer. Duration: one week.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. N. Legg M.D. M. D. or other

Address Union Bridge Date signed 11-3-39

RECEIVED
DEC 4 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

10861

Reg. Dist. No. 81

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Union Bridge
(If outside city or town limits, write RURAL NEAR end give town)

Street address, hospital, or institution: White Street

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Union Bridge Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. White Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Reuben Devilbiss

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Susie Bisely Devilbiss

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11 - 1862

8. AGE:

Years	Months	Days	If less than one day
77	7	28	hrs. min.

9. Birthplace Frederick Co. Maryland
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Retired

FATHER
12. Name Adam A Devilbiss
13. Birthplace Carroll Co. Maryland

MOTHER
14. Maiden name Anna Mariah Greenwood
15. Birthplace Carroll Co. Maryland

16. Informant Grover Devilbiss
Address Union Bridge Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 12. 1939 (month) (day) (year)

Cemetery or crematory Winters Church Cemetery

Location Union Bridge - New Windsor Road

18. Funeral director D. D. Hartle & Sons

Address Union Bridge & New Windsor Maryland

19. Nov. 10 1939 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 9 1939, at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 8 1939, to Nov 9 1939, and that I last saw him alive on Nov 9 1939

Immediate cause of death	DURATION
Congna Pectoris	
Due to Arteris Sclerosis	
Due to	
Other conditions -	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. N. Legg
M. D. or other

Address Union Bridge Date signed 11-10-39

RECEIVED
DEC 5 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

10862

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days) 3 yrs. 2 Mo. 17 Das.
Stay in this community (yrs., or mos., or days) (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 1028 McDonough St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Anna Elizabeth Eaton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

8 (b) Name of husband or wife ---
6(c) If alive, give age ---- years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1918

8. AGE: Years	Months	Days	If less than one day
21	9	18	---- hrs. ---- min.

9. Birthplace Littleton, N. C.
(Town, county, and state)
10. Usual occupation Scholar
11. Industry or business

FATHER
12. Name John Eaton
13. Birthplace Littleton, N. C.

MOTHER
14. Maiden name Bessie Eaton
15. Birthplace Littleton, N. C.

16. Informant Dr. Reuben Hoffman
Address Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/26/39 (month) (day) (year)
Cemetery or crematory Mt. Calvary Cem.
Location Dalto, Md.
18. Funeral director Joseph S. Licks, Jr.
Address 1304 N. Central Ave.
19. 11/22/39 (Date rec'd by registrar) 19 Albert R. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22, 1939 19 ---, at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 26, 1936 19 --- to Nov. 22, 1939 19 ---, and that I last saw h-er alive on Nov. 22, 1939 19 ---

Immediate cause of death Tuberculous Meningitis — DURATION Nov. 1939
Due to Pulmonary Tuberculosis — DURATION April 1936
Due to ---
Other conditions ---
(Include pregnancy within 3 months of death)
Major findings:
Of operations ---
Of autopsy No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of -
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ---
Means of injury -- Injured at work? --

23. SIGNATURE Reuben Hoffman M. D.
M. D. or other
Address Henryton, Maryland Date signed 11/22/39

NOV 27
BUR

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10863

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County CARROLL

City or town LINEBORO

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 74 YRS.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County CARROLL

City or town LINEBORO Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME WARNER J. FRANK

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife CLARA M HETRICK

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 28 1865

8. AGE: Years 74 Months 3 Days 4 If less than one day hrs. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation CATTLE DEALER

11. Industry or business

FATHER 12. Name HENRY WARNER

13. Birthplace MARYLAND

MOTHER 14. Maiden name REBECCA ROHRBAUGH

15. Birthplace PENNSYLVANIA

16. Informant Maurice E Warner

Address Linebro Md

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof Nov. 4, 1939 (month) (day) (year)

Cemetery or crematory LINEBORO MD

Location

18. Funeral director Geo W. Geidel & Son

Address Glen Rock Pa.

19. Nov. 3 1939 Mrs. W. P. S. Denner

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 2 1939, at 3 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27 1937 to Nov 2 1939 and that I last saw him alive on Oct 31 1939

Immediate cause of death	DURATION
Cerebral Hemorrhage	28 mos
Due to Hypertension & Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W R S Denner M. D. or other

Address Manchester Md Date signed 11/3/39

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (23)

10864

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 3 mo. 2 days
Stay in this community (yrs., or mos., or days): same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 1522 Fairmount Avenue
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: August Francis

3. (b) Social Security Number:

4. Sex: Male
5. Color or race: Colored
6. (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: ---
--- 6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): August 25, 1894

8. AGE: Years: 45 Months: 2 Days: 20 If less than one day ____ hrs. ____ min.

9. Birthplace: Portugal (Town, county, and state)
10. Usual occupation: Seaman
11. Industry or business: ----

FATHER
12. Name: Manuel Francis
13. Birthplace: Portugal

MOTHER
14. Maiden name: Mary Forts
15. Birthplace: Portugal

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Nov 21. 1939 (month) (day) (year)
Cemetery or crematory: City Morgue
Location: Balto. Md.

18. Funeral director: S. J. Hemsley
Address: 518 W. Biddle St. Balto. Md

19. 11/1/4/39 (Date rec'd by registrar) 19 Albert R Swankham Deputy Lacal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 14, 1939, at 12.45 A. M

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from Aug., 12 1939, to Nov., 14, 1939, and that I last saw him alive on November 14, 1939.

Immediate cause of death: Pulmonary Tuberculosis
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations: ---
Of autopsy: ---

DURATION: May 1939

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 11/14/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (742)

CERTIFICATE OF DEATH

10865

Reg. Dist. No. 7 D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Taneytown
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town: Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mrs. Lavina S. Fringer

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife: James F. Fringer 6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 10, 1867

8. AGE: Years	Months	Days	If less than one day
72	0	29	hrs. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Manager Telephone Exchange

FATHER
12. Name: George Shoemaker
13. Birthplace: Md.

MOTHER
14. Maiden name: Clarinda Hess,
15. Birthplace: Md.

16. Informant: Mrs. Frank L. Brown
Address: Columbus, Ohio.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 12, 1939 (month) (day) (year)
Cemetery or crematory: Lutheran
Location: Taneytown

18. Funeral director: C.O. FUSS & SON
Address: Taneytown, Md.

19. Nov 11 1939 (Date rec'd by registrar) Ethel M. Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 9th 1939, at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 27 Th 1939 to Nov 9th 1939 and that I last saw h-e alive on Nov 9th 1939

Immediate cause of death	DURATION
Angina Pectoris	10 min
Due to	
Due to	
Other conditions: Suffered from Angina Pectoris since Mar 27th 1939 (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. M. Benner M.D. M. D. or other
Address: Taneytown Md. Date signed 11/11/39

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10866

Reg. Dist. No. 70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Taneytown
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 73 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County

City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME G.F.Sherman Gilds

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Laura Marquet Gilds

6(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) March 3, 1866

8. AGE: Years	Months	Days	If less than one day
73	8	8	hrs. min.

9. Birthplace Md
(Town, county, and state)

10. Usual occupation retired tinsmith

11. Industry or business

FATHER 12. Name William Gilds

13. Birthplace Md.

MOTHER 14. Maiden name Emily Miller

15. Birthplace Md

16. Informant Mrs. Laura Gilds

Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 14, 1939 (month) (day) (year)

Cemetery or crematory Lutheran

Location Taneytown

18. Funeral director C.O.FUSS & SON

Address Taneytown, Md.

19. Nov 11. 1939 (Date rec'd by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11th 1939, at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1 1939, to Nov 11 1939, and that I last saw him alive on Nov 10 1939

Immediate cause of death Cerebral Hemorrhage — DURATION four minutes

Due to Arterio Sclerosis — 2 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. M. Benner M.D. M. D. or other

Address Taneytown Md Date signed 11/11/39

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BUREAU V. S.

10867

STATE OF MARYLAND—CERTIFICATE OF DEATH

(131)

1. PLACE OF DEATH

County Carroll Registration Dist. No. 76

Village or City Gamber No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 8 yrs. 6 mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Emma Maud Harden.

(a) Residence: No. None. Gamber St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE white

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Maulden L. Harden

6. DATE OF BIRTH (month, day, and year) May 20, 1875

7. AGE Years 64 Months 6 Days 1 If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. House wife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. —

10. Date deceased last worked at this occupation (month and year) 1932

11. Total time (years) spent in this occupation 40 yrs.

12. BIRTHPLACE (city or town) Reisterstown (State or country) Md.

FATHER

13. NAME Amos Naylor

14. BIRTHPLACE (city or town) Hereford (State or country) Md.

MOTHER

15. MAIDEN NAME Emma Olivia Achurst

16. BIRTHPLACE (city or town) Mt. Washington (State or country) Md.

17. INFORMANT Maulden Leroy Harden Jr. (Address) 99 Lark St. Albany N.Y.

18. BURIAL, CREMATION, OR REMOVAL Place Mt. Pleasant Date Nov. 23, 1939

19. UNDERTAKER Upper Berryman & Sons (Address) Reisterstown, Md.

20. FILED 11/22, 1939 C. P. Fagle Dep. Rec. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH November (Month) 21 (Day), 1939 (Year)

22. I HEREBY CERTIFY That I attended deceased from 1935, 19, to death, 19

I last saw her alive on Nov 21, 1939; death is said to have occurred on the date stated above, at 7:00 A.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	
Hypertension	
Nephritis (chronic interstitial)	

Other Contributory Causes of importance:

Oedema of Lungs

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) W. H. Lawson M. D.

(Address) Sykesville

B/P #7

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

10868

CERTIFICATE OF DEATH

Reg. Dist. No. 71

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll (Uniontown Dist.)
City or town Westminster, Md R. D. 7
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 59-11-19

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster Rural Route #7 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. near Tyrone & Mayberry
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Oliver Laurence Heltibridle

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Annie Ring (Heltibridle)
6(c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Nov. 23-1879

8. AGE: Years	Months	Days	If less than one day
59	11	19	hrs. min.

9. Birthplace Carroll Co. Maryland
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business Farmer
FATHER 12. Name Aaron Heltibridle
13. Birthplace Carroll Co. Md.
MOTHER 14. Maiden name Sarah Yarnwalt
15. Birthplace Carroll Co. Md.
16. Informant Mrs Annie Heltibridle
Address Westminster Md. R. D. 7.
17. Burial (Burial, cremation, or removal. Which?) Date thereof NOV 15-1939 (month) (day) (year)
Cemetery or crematory St Marys (Methodist Epis.)
Location Silver Run Md
18. Funeral director J. W. Little & Son per P. A. L.
Address Littlestown Penna.
19. Nov. 15 1939 (Date rec'd by registrar) Margaret R. England Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12, 1939 at 5:10 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27 1939, to Nov. 12 1939, and that I last saw him alive on Nov. 11, 1939.

Immediate cause of death	Hemiplegia	DURATION
Due to	Cerebral embolism	
Due to	Endocarditis; Chronic. Cause.	
Other conditions	Chronic nephritis. Duration: more than six months	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE E. Reese Wilkens, M.D.
M. D. or other
Address Westminster Md. Date signed Nov 12 1939

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (92a)

10869

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Lykesville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital
Stay in hospital or inst. (yrs., or mos., or days) 24 yr. 2 mo. 10 da
Stay in this community (yrs., or mos., or days) 46 yr 2 mo 27 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 3050 W. North Avenue
(If rural give LOCATION)
2(a) IF YETERAN, NAME WAR

3. (a) FULL NAME Katie Hoopman

3. (b) Social Security Number

4. Sex F.
5. Color or race W.
6. (a) Single, married, widowed, or divorced separated
6 (b) Name of husband or wife (Unknown) Hoopman
Unknown B(c) If alive, give age Unkn years
7. Birth date of deceased (mo., day, yr.) June 5, 1869.

8. AGE: Years 70 Months 5 Days 6 If less than one day ___ hrs. ___ min.

9. Birthplace Baltimore, Maryland.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name (Unknown) Webb
13. Birthplace Virginia
MOTHER 14. Maiden name Mary R. Hall
15. Birthplace Virginia
16. Informant Hospital Records
Address Lykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 16 1939 (month) (day) (year)
Cemetery or crematory Chester
Location Penna.
18. Funeral director N. Bankard & Son
Address Westminster Md.
19. Nov 13 1939 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11, 1939, at 12.50 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1st, 1939, to Nov. 11 1939 and that I last saw her alive on Nov. 10, 1939.

Immediate cause of death General Arteriosclerosis
Due to Aus Mitral and aortic insufficiency
Due to
Other conditions Schizophrenia
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION
1926
1915

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Maud M. Rees M.D.
M. D. or other
Address Lykesville Md. Date signed 11-12-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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DEC 4 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

10870

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days) 1 yr. 2 Mo. 13 days
Stay in this community (yrs., or mos., or days) same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 610 W. Lee Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME Bennie Percil Jackson

3. (b) Social Security Number 218-01-7677

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife ---

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Feb., 22, 1916

8. AGE:

Years	Months	Days	If less than one day
23	8	22	____ hrs. ____ min.

9. Birthplace Blackstone, Virginia (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business Unknown
FATHER 12. Name Percil Jackson
13. Birthplace Blackstone, Va.
MOTHER 14. Maiden name Gertrude Yates
15. Birthplace Blackstone, Va.
16. Informant Reuben Hoffman, M. D.
Address Henryton, Md.
17. ____ (Burial, cremation, or removal. Which?) Date thereof Nov. 16, 39 (month) (day) (year)
Cemetery or crematory Mt. Calvary
Location Cedar Lee Md.
18. Funeral director James A. Hayes
Address 142 W. Lee St.
19. 11/13/39 (Date rec'd by registrar) Albert R. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13, 1939, at 4 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb., 22, 1939 to Nov., 13, 1939
and that I last saw him alive on November 13, 1939

Immediate cause of death	Pulmonary Tuberculosis	DURATION
Due to		April 1938
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings:
Of operations ----
Of autopsy ----

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide --- Date of ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ---
Means of injury -- Injured at work? ---

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other
Address Henryton, Md. Date signed 11/13/39

RECEIVED
DEC 4 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107-a

CERTIFICATE OF DEATH

10871

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Sykesville, Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 60 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Balto.
City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 337 S. Bauldin Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John Krause

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Cenelia Franke
6(c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) November 27, 1864

8. AGE: Years 75 | Months no | Days no | If less than one day ____ hrs. ____ min.

9. Birthplace Danzig - Germany
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name John Anthony Krause
13. Birthplace Germany

MOTHER
14. Maiden name Wilhemina Jane Feki
15. Birthplace Poland

16. Informant Hospital Records
Address Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-30-39 (month) (day) (year)
Cemetery or crematory Sacred Heart
Location O'Donnell St., Bel.

18. Funeral director John G. Connelly
Address Essex, Md.

19. Nov 27 1939 (Date rec'd by registrar) Catharine Beer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 1939, at 5:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 28 1939, to November 27 1939, and that I last saw him alive on November 26 1939.

Immediate cause of death	DURATION
Arteriosclerosis	1926
Due to Cerebral Infarct	Known at autopsy
Right Temporal Lobe	
Due to Bronchopneumonia	Nov. 24. 39
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy As above

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M. Virginia Beyer M.D.
M. D. or other
Address Sykesville, Md. Date signed Nov. 27. 39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 4 1939
BUREAU V. S.

10872

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82-12)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 5 days

Stay in this community (yrs., or mos., or days): 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 1701 Bloomingdale Road
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: John C. Lurssen

3. (b) Social Security Number:

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Clara Bartholomaei

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Aug. 16, 1877

8. AGE: Years: 62 Months: 2 Days: 20 If less than one day ____ hrs. ____ min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Store-keeper

11. Industry or business:

FATHER
12. Name: Charles C. Lurssen
13. Birthplace: Germany

MOTHER
14. Maiden name: Anna M. Siemers
15. Birthplace: Maryland

16. Informant: Clara Louise Lurssen

Address: 1701 Bloomingdale Road, Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 8 39 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Fred K. Rd. Balto Md

18. Funeral director: Wm. J. Pickus & Sons

Address: North & Pa Ave Balto Md.

19. Nov 6 1939 (Date rec'd by registrar) C. Harry Weir Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 5 1939, at 9:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 1939, to Nov. 5 1939, and that I last saw him alive on Nov. 5, 1939.

Immediate cause of death	DURATION
Arteriosclerosis, generalized	11-1-39 (Known)
Cerebral hemorrhage	? 1½ yrs. ago
Due to Bronchopneumonia, primary	2 days
Due to	
Other conditions Paralysis agitans	1½ yrs.

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: M. Virginia Beyer M.D. (M. D. or other)

Address: Sykesville, Md. Date signed: 11-6-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

J. C. Jurgesen
Death Certificate

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10873

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 4 Mos. 15 Days.
Stay in this community (yrs., or mos., or days): (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 1015 N. Caroline St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Aleatha Lynch (Maker)

3. (b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife: William Maker

6(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): June 4, 1911

8. AGE:

Years	Months	Days	If less than one day
28	5	28	---- hrs. ---- min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: ---

FATHER
12. Name: James Griffin
13. Birthplace: Chase, Maryland

MOTHER
14. Maiden name: Mamie Williams
15. Birthplace: Pocomoke City, Md.

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/28/39 (month) (day) (year)
Cemetery or crematory: St. Stevens
Location: Essex Md

18. Funeral director: Mrs. R. H. A. Elliott
Address: 1129 N. Caroline St

19. 11/25/39 (Date rec'd by registrar) 19 Albert R. Swankland Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 25, 1939 10:00 A.M. 19 ---, at --- M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10, 1939 19 --- to November 25 19 39
and that I last saw her alive on Nov. 25, 1939 19 ---

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Nov. 1938
Due to ---	
Due to ---	
Other conditions ---	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: ---
Of autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of --
Where did injury occur? --- (City or town) --- (County) --- (State)
Injured at home, farm, industry, public place (where?) ---
Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D.
Address: Henryton, Maryland M. D. or other
Date signed: 11/25/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 4 1939
BUREAU V. S.

10874

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 50 Webster Street

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 30 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 50 Webster
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Eliza Jane Mathias

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	married

6 (b) Name of husband ~~or wife~~ Jacob Mathias

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Jan. 10 - 1857

8. AGE:

Years	Months	Days	If less than one day
82	8	22	____ hrs. ____ min.

9. Birthplace Carroll County, Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Lewis Green
13. Birthplace Maryland

MOTHER
14. Maiden name Nancy Miller
15. Birthplace Maryland

16. Informant Mrs Charles Magin

Address Westminster Maryland

17. Burial Date thereof Nov. 5 - 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lusters Cemetery

Location Nr. Westminster Maryland

18. Funeral director H. Bankard & Son

Address Westminster, Maryland

19. 11/3 1939 [signature]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 2 1939, at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1939, to Nov 2 1939, and that I last saw her alive on Nov 1 1939.

Immediate cause of death Chronic Nephritis Arteriosclerosis General.

DURATION 2 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Glenn Speicher
M. D. or other

Address Westminster Md Date signed Nov 3/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M) (T)

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DEC 5 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (210-m)

10875

CERTIFICATE OF DEATH

Reg. Dist. No. 70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Taneytown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: —
Stay in hospital or inst. (yrs., or mos., or days) —
Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State — County —
City or town — Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Geraldine Rae Miller

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife — Not Married

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 25, 1933

8. AGE: Years 6 | Months 7 | Days [illegible] | If less than one day — hrs. — min.

9. Birthplace Frederick County
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name Ray Miller
13. Birthplace Md

MOTHER
14. Maiden name Marie Long
15. Birthplace Md.

16. Informant Charles Otto Keyman Md.
Address —

17. Burial, cremation, or removal. Which? Burial Date thereof Nov 28, 1939 (month) (day) (year)
Cemetery or crematory Mt Hope
Location Woodsboro, Md.

18. Funeral director C O Russ Boon
Address Taneytown, Md.

19 Nov. 28 1939 (Date rec'd by registrar) Mary B Hill Registrar Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1939 about at 11 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 — to — 19 —, and that I last saw h — alive on — 19 —.

Immediate cause of death	DURATION
Fracture Skull	
Due to Automobile accident	
Due to —	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 11/25/39
Where did injury occur? Taneytown (City or town) Carroll (County) Md (State)
Injured at home, farm, industry, public place (where?) Public road
Means of injury Automobile Accident Injured at work?

23. SIGNATURE J. Marsh Deputy Medical Examiner M. D. or other
Address New Windsor Md Date signed 11/26/39

RECEIVED
DEC 2 1939
BUREAU V. S.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (128)

CERTIFICATE OF DEATH

10876

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days) 16 days.

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 1409 Cliftview Ave.,
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Silvian Mongold

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Leonard Mongold

6(c) If alive, give age unknown years

7. Birth date of deceased (mo., day, yr.) October 14 - 1910

8. AGE:

Years	Months	Days	If less than one day
29		24	hrs. min.

9. Birthplace Spotsville, Virginia
(Town, county, and state)

10. Usual occupation Machine Operator

11. Industry or business Factory

FATHER
12. Name Mark J. Smith
13. Birthplace Maryland

MOTHER
14. Maiden name Myrtle Faulconer
15. Birthplace Virginia

16. Informant Hospital Records -

Address Sykesville, Md -

17. Burial Date thereof Nov 11-1939
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory London Park

Location Baltimore Md.

18. Funeral director Bertram Moore

Address 2224 N. Charles St.

19. Nov 8 1939 C. Harry Heer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8 1939, at 12:10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 23 1939, to November 8 1939, and that I last saw her alive on November 7 1939.

Immediate cause of death	DURATION
Acute Hemorrhagic Pancreatitis	Oct. 10-'39
Due to Peritonitis	Oct. 23-'39
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations Acute Hemorrhagic Pancreatitis (St. Josephs Hospital)
Of autopsy Necrosis of Abdominal Fat.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. Virginia Beyer M.D.
M. D. or other

Address Sykesville, Md. Date signed Nov 8-1939

RECEIVED
NOV 9 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (34)

10877

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or Inst. (yrs., or mos., or days): 11 mos.,24 days.

Stay in this community (yrs., or mos., or days): 11 mos.,24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 820 Washington Boulevard (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Allen Joseph Newton

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Margaret Fowler

6(c) If alive, give age: 25 years

7. Birth date of deceased (mo., day, yr.): Sept. 22,1900

8. AGE: Years	Months	Days	If less than one day
39	1	13	hrs. min.

9. Birthplace (town, county, and state): Jacksonville, Florida

10. Usual occupation: Telegraph operator

11. Industry or business: Race track

FATHER — 12. Name: Julius Newton

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Hospital Record

Address

17. Burial (Burial, cremation, or removal. Which?), Date thereof Nov 8 1939 (month) (day) (year)

Cemetery or crematory: Springfield

Location: Sykesville Md.

18. Funeral director: C. A. Kees

Address: Sykesville Md.

19. Nov 7 1939 (Date rec'd by registrar) C. Nancy Kees Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: BETWEEN Oct. 26 & Nov. 4 1939, at M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 19, to 19, and that I last saw h alive on 19.

Immediate cause of death	DURATION
Exposure to Hunger & Cold.	
Due to Neurosyphilis	2 Yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide: Accident Date of: 11/4/39

Where did injury occur? Sykesville (City or town) Carroll (County) Md. (State)

Injured at home, farm, industry, public place (Name): Springfield State Hospital

Means of injury: Injured at work? —

23. SIGNATURE: J. T. Shank Deputy Medical Examiner M. D. or other

Address: New Windsor Md. Date signed 11/7/39

RECEIVED
DEC 4 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (93-d) Reg. Dist. No. 74

CERTIFICATE OF DEATH

10878

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Sykesville (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Springfield State Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19, 9,

(e) Length of stay in this community (yrs., mos., or days) Same

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Baltimore City

(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)

(d) Street No. 3404 Eastern Ave., Balto., Md 6. (If rural give location)

(e) If foreign born, how long in U. S. A.? --- years

3 (a) **FULL NAME** Henry F. Ortel

3 (b) If veteran, name war ----

3 (c) Social Security No. ------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Nellie Peterson

6. (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1891

8. AGE: Years	Months	Days	If less than one day
47	10	9	____hr. ____min.

9. Birthplace Baltimore Co., Md. (Town, county, and state)

10. Usual occupation Dentist

11. Industry or business Dentist

FATHER 12. Name Henry Ortel

FATHER 13. Birthplace Baltimore Co., Md.

MOTHER 14. Maiden Name Mary M. Krupp

MOTHER 15. Birthplace Baltimore Co., Md.

16 (a) Informant Records of Springfield

(b) Address State Hospital, Sykesville, Maryland.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 11, 1939 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem.

Location Baltimore, Md.

18 (a) Funeral director John O. Mitchell

(b) Address Baltimore, Md.

19 (a) Nov. 8, 1939 (Date rec'd by registrar) (b) A. Kenny Ween Registrar

MEDICAL CERTIFICATION

20. Date of death November 8, 1939 at 3:10 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/2/20 19___, to 11/8/39 19___, and that I last saw him alive on Nov. 7th 19. 39.

Immediate cause of death	Duration
Myocardial infarction	11/8/39
Due to Arteriosclerosis	?
Due to	
Other conditions Bronchopneumonia	10/22/39

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide ------

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Samuel Bakoff M.D. M. D. or other

Address Sykesville, Md Date signed 11/8/39

RECEIVED
NOV 18 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (46-C)

10879

CERTIFICATE OF DEATH

Reg. Dist. No. 81.

1. PLACE OF DEATH:
County Carroll County
City or town Union Bridge, Md. (outside)
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary Ida Reese

3. (b) Social Security Number

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Harry C. Reese
Union Bridge, Md 6(c) If alive, give age 62 years
7. Birth date of deceased (mo., day, yr.) Oct. 10, 1881

8. AGE: Years 58 | Months 1 | Days 13 | If less than one day ___ hrs. ___ min.

8. Birthplace Carroll Co. (Town, county, and state)
10. Usual occupation House Wife
11. Industry or business
FATHER 12. Name Joel Myers
13. Birthplace Carroll Co.
MOTHER 14. Maiden name Mary E. Scherfey
15. Birthplace Unkown
16. Informant Harry C. Reese
Address Union Bridge, Md.
17. Burrial (Burial, cremation, or removal. Which?) Date thereof Nov 26-39 (month) (day) (year)
Cemetery or crematory Pipe Creek
Location Near Uniontown Md.
18. Funeral director Raymond K. Wright
Address Union Bridge, Md.
19. Nov. 25 1939 (Date rec'd by registrar) P. Eichman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23 1939, at 35 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1939, to November 23 1939, and that I last saw her alive on November 22 1939.

Immediate cause of death: Carcinoma of liver — DURATION: 9 mos.
Due to Carcinoma of Colon — ?
Due to Patient had pronounced symptoms, when physician first saw the case, both colon and liver
Other conditions being involved. He does not know whether the cancer was primary in colon or liver. C.W.G.R.
(Include pregnancy within 3 months of death)
Major findings
Of operations Carcinoma of Colon and liver
Of autopsy None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Jas. T. Sharch M. D. M. D. or other
Address New Windsor Md Date signed 11/23/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

RECEIVED
DEC 5 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-C) Vc

CERTIFICATE OF DEATH

10880

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days) 5 days

Stay in this community (yrs., or mos., or days) 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Towson Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 332 Ridge Ave.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Edwin Riley

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Mrs. Clara Riley

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1860

8. AGE: Years	Months	Days	If less than one day
79	9	8	____ hrs. ____ min.

9. Birthplace Phoenix, Md. (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business State roads

FATHER 12. Name ? John Riley

FATHER 13. Birthplace ? Maryland

MOTHER 14. Maiden name ? Whitemore

MOTHER 15. Birthplace ? Md.

16. Informant Mrs. Clara Riley

Address 332 Ridge Ave., Towson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 7, 1939 (month) (day) (year)

Cemetery or crematory Poplar Cem.

Location Balto. Co. Md.

18. Funeral director John Burns' Sons

Address Towson, Md.

19. Nov. 4 1939 (Date rec'd by registrar) C. Harry Steer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. Oct. 4 1939 at 2:05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 27 1939, to Nov. 4 1939, and that I last saw him alive on Nov. 3 1939.

Immediate cause of death	DURATION
Arteriosclerosis, generalized	10/27/39
Cerebral hemorrhage	(1939)
Due to Myocardial degeneration	10/27/39
	(Known)
Due to Hypostatic pneumonia	11/1/39
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. Virginia Bayer M.D. M. D. or other

Address Sykesville, Md. Date signed

VS A15 (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 13 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

10881

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days) 3 yrs. 6 Mos. 21 Das.
Stay in this community (yrs., or mos., or days) (Same As Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 925 Hubbard Alley
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Willie May Scott

3. (b) Social Security Number ---

4. Sex: Female
5. Color or race: Colored
6. (a) Single, married, widowed, or divorced: Married
8 (b) Name of husband or wife: Unknown
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): June 1, 1905

8. AGE: Years 34 | Months 5 | Days 21 | If less than one day ____ hrs. ____ min.

9. Birthplace: Portsmouth, Va. (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: ---

FATHER
12. Name: Patrick Davis
13. Birthplace: West Point, Va.

MOTHER
14. Maiden name: Cora Burrell
15. Birthplace: Portsmouth, Va.

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof 12-1-39 (month) (day) (year)
Cemetery or crematory
Location: Portsmouth — Va.
18. Funeral director: Mrs. Katie R. Williams
Address: 322 N. Schroeder St.

19. 11/27/39 (Date rec'd by registrar) 19 Deputy Local Registrar: Albert R. Swankhouse

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27, 1939 19 1:40 A.M. et M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6, 1936 19 to Nov. 27, 1939 and that I last saw her alive on Nov. 27, 1939 19

Immediate cause of death: Pulmonary Tuberculosis — DURATION: April 1936
Due to --
Due to --
Other conditions --
(Include pregnancy within 3 months of death)
Major findings:
Of operations --
Of autopsy No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide -- Date of
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ---
Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Maryland Date signed 11/27/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 4 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93C)

CERTIFICATE OF DEATH

10882

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 55 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural near Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Frank Shaeffer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

B (b) Name of husband or wife: Mary L. Tressler

6(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): September 13, 1884

8. AGE: Years	Months	Days	If less than one day
55	2	9	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: John D. Shaeffer
13. Birthplace: Maryland

MOTHER
14. Maiden name: Lydia E. Arbaugh
15. Birthplace: Maryland

16. Informant: Mrs. Frank Shaeffer
Address: Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/25/39 (month) (day) (year)

Cemetery or crematory: Krider's Cemetery

Location: Westminster, Md.

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. [signature] (Date rec'd by registrar) 19 [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 22, 1939, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-18-1939, to 11-22-1939 and that I last saw him alive on 11-22-1939.

Immediate cause of death: Myocarditis (Chr) — DURATION
Acute Cold — 11-15-39
Pleurisy — 11-18-39

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. C. Jennette M.D. (M. D. or other)
Address: Westminster Md. Date signed: 11-23-39

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 5 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-C)

10883

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: #1 E. Main Street

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 40 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. #1 E. Main
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Margaret Alice Sheets

3. (b) Social Security Number

4. Sex: F

5. Color or race: W

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~ J. Edwin Sheets

6(c) If alive, give age ___ years

7. Birth date of deceased (mo., day, yr.) July 3. 1869

8. AGE: Years 70 | Months 3 | Days 29 | If less than one day ___ hrs. ___ min.

9. Birthplace Mayberry, Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Emanuel Erb
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden name not known
15. Birthplace

16. Informant J. Edwin Sheets
Address #1 E. Main St. Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 4 - 1939 (month) (day) (year)

Cemetery or crematory Silverrun Cemetery

Location Silverrun Carroll Co. Maryland

18. Funeral director H. Bankard & Son

Address Westminster Maryland

19. 11/3 1939 L. K. Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2nd 39, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/2 1939, to 11/2 1939 and that I last saw her alive on 11/2 1939.

Immediate cause of death Coronary Thrombosis — DURATION 10 mins

Due to Chronic Myocarditis — Unknown

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. K. Woodward, M.D.
M. D. or other

Address Westminster Date signed 11/3/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 5 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

CERTIFICATE OF DEATH

10884

Reg. Dist. No. 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. E. Main
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME ("Moe") Charles Ashley Shipley

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6 (b) Name of husband or wife —
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
about 5'5"			____ hrs. ____ min.

9. Birthplace Not Known
(Town, county, and state)
10. Usual occupation Dish Washer - Restaurant
11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden name —
15. Birthplace

16. Informant Geo. Bingaman
Address Westminster Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 5 1939 (month) (day) (year)
Cemetery or crematory County Home Cemetery
Location Rs. Westminster Maryland
18. Funeral director H. Bankard & Son
Address Westminster Md
19. 11/4 (Date rec'd by registrar) 19 39 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1939, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 31 1939, to Nov. 3 1939, and that I last saw h[illegible] alive on Oct. 31 1939

Immediate cause of death	DURATION
Myocarditis (chronic)	
Nephritis (chronic)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. C. Jennette M.D.
M. D. or other
Address Westminster Date signed Md.

RECEIVED
DEC 5 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10885

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: rural near Westminster

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): ---

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: rural near Westminster Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: (Infant) Stephan

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife

6(c) If alive, give age ---- years

7. Birth date of deceased (mo., day, yr.): November 9, 1939

8. AGE:

Years	Months	Days	If less than one day
0	0	0	0 hrs. 0 min.

9. Birthplace: Westminster, Carroll, Md.

(Town, county, and state)

10. Usual occupation ---

11. Industry or business ---

FATHER

12. Name: Paul Stephan

13. Birthplace: Maryland

MOTHER

14. Maiden name: Florence C. Williams

15. Birthplace: Maryland

16. Informant: Paul Stephan

Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 11/9/39 (month) (day) (year)

Cemetery or crematory: Kriders Cemetery

Location: Westminster, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 11/9 (Date rec'd by registrar) 1939 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 9 1939, at 5:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 9 '39, to Nov 9 1939, and that I last saw h[illegible] alive on Nov 9 1939.

Immediate cause of death	DURATION
Pressure + Strangulation Card. Probable Cerebral Hem	
Due to Prolonged labor	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Glenn Speicher M. D. or other

Address Westminster Md. Date signed Nov 9.

RECEIVED
DEC 5 1939
BUREAU V. S.

10886

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (51-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH:

County Carroll

City or town near Hampstead

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 62 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town near Hampstead Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Burton W Taylor.

3. (b) Social Security Number ✓

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ or wife Maggie Hatten

6(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Jan 29 - 1877

8. AGE: Years 62 Months 9 Days 19 If less than one day ____ hrs. ____ min.

9. Birthplace Carroll Co Maryland (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Watson Taylor

13. Birthplace Maryland

MOTHER 14. Maiden name Eliza Evans

15. Birthplace Maryland

16. Informant Mrs Burton W Taylor

Address Tipperco Md.

17. Balto (Burial, cremation, or removal. Which?) Date thereof Nov 21/39 (month) (day) (year)

Cemetery or crematory Wesley.

Location near Hampstead Md.

18. Funeral director Edw C Tipton

Address Hampstead Md

19. Nov 19 1939 (Date rec'd by registrar) John S. Hughes Jr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 1939, at 11:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1939, to Nov. 18 1939, and that I last saw him alive on Nov. 18 1939.

Immediate cause of death Carcinoma of Prostate with metastasis to bones of pelvis, liver and lungs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION: 8 mo

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Maurice C. Partnefield MD M.D. or other

Address Hampstead Date signed 11-19-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 2 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-C)

CERTIFICATE OF DEATH

10887

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Taylorsville (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 2 yrs 4 mos

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Baltimore

City or town: Baltimore Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 521 Holbrook St (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Apolonia Walter

3. (b) Social Security Number:

4. Sex: female

5. Color or race: white

6. (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: —

6 (c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): March 4th - 1849

8. AGE: Years: 90 Months: 8 Days: 9 If less than one day: hrs. min.

9. Birthplace: Alsace France (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER 12. Name: Anthony Walter

FATHER 13. Birthplace: Alsace France

MOTHER 14. Maiden name: Odilia Gahring

MOTHER 15. Birthplace: France

16. Informant: Mrs Mary Schneider

Address: 521 Holbrook St Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 15 1939 (month) (day) (year)

Cemetery or crematory: Holy Redeemer Cem.

Location: Balto Md

18. Funeral director: Henry Hoeck & Son Inc

Address: 1301 E. Eager St

19. Nov 13 1939 (Date rec'd by registrar) Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 13th 1939 at 10-10a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6 1932 to Nov 13 1939 and that I last saw h— alive on Nov 13 1939.

	DURATION
Immediate cause of death: Chronic Myocarditis	9
Due to: Arteriosclerosis	9
Due to: Hypertension	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. H. Master M. D. or Other

Address: Taylorsville Md Date signed Nov 13/39

RECEIVED
NOV 28 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23

10888

CERTIFICATE OF DEATH

Reg. Dist. No. 74

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch,
Stay in hospital or inst. (yrs., or mos., or days) 1 Mo. 2 days
Stay in this community (yrs., or mos., or days) (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 226 S. Caroline St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR ---

3. (a) FULL NAME Carrie Ward

3. (b) Social Security Number ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife ---
6(c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1894

8. AGE:

Years	Months	Days	If less than one day
44	11	2	---hrs. ---min.

9. Birthplace Rockypoint, N. C.
(Town, county, and state)
10. Usual occupation Farm worker
11. Industry or business O---

FATHER
12. Name Isaac Carl
13. Birthplace Rockypoint, N. C.

MOTHER
14. Maiden name Minnie Van
15. Birthplace Rockpoint, N. C.

16. Informant Dr. Reuben Hoffman
Address Henryton, Maryland

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Nov 28 1939 (month) (day) (year)
Cemetery or crematory Balto. City Morgue
Location Balto. Md.
18. Funeral director Mrs S. J. Hemsley
Address 518 N. Kidde St. Balto. Md.

19. 11/27/39 (Date rec'd by registrar) Albert R. Swankham Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27, 1939 19--- 11:00 P.M. at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 25, 1939 19--- to Nov. 27, 1939 19---, and that I last saw her alive on Nov. 27, 1939 19---

Immediate cause of death Pulmonary Tuberculosis — DURATION June 1939
Due to ---
Due to ---
Other conditions ---
(Include pregnancy within 3 months of death)
Major findings:
Of operations ---
Of autopsy No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide --- Date of ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ---
Means of injury --- Injured at work? ---

23. SIGNATURE Reuben Hoffman M.D. M. D. or other
Address Henryton, Maryland Date signed 11/27/39

RECEIVED
DEC 4 1936
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

10889

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Manchester
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or Institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) May 1928

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Manchester Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Nelson Warehime

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: (Deceased) Sarah J. Warehime
6(c) If alive, give age: C years
7. Birth date of deceased (mo., day, yr.): June 23 1848
8. AGE: Years 91 Months 4 Days 10 If less than one day: hrs. min.
9. Birthplace: Maryland Carroll Co., (town, county, and state)
10. Usual occupation: Cigar Mfgr
11. Industry or business
FATHER 12. Name: Conrad Warehime
13. Birthplace: Maryland
MOTHER 14. Maiden name: Cathren Stansbury
15. Birthplace: Maryland
16. Informant: Mrs. Robert Shower
Address: Manchester Md
17. Burial (Burial, cremation, or removal? Which?) Date thereof 11 6 1939 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Manchester Md
18. Funeral director: Jacob Winks Sons
Address: Manchester Md
19. Nov 6 1939 (Date rec'd by registrar) Mrs. M. P. S. Denner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 4 1939, at 2 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1939, to Nov 4 1939, and that I last saw him alive on Nov 3 1939

	DURATION
Immediate cause of death: Arteriosclerosis	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W R S Denner M. D. or other
Address Manchester Md Date signed

RECEIVED
DEC 4 1969
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10890

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
Maryland Tuberculosis Sanatorium
Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 2 yrs 9 mo. 29 days

Stay in this community (yrs., or mos., or days): same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 1011 W. Sterling Court
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ---

3. (a) FULL NAME: Robert Weems

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife: ---

6(c) If alive, give age: ---

7. Birth date of deceased (mo., day, yr.): Sept., 21, 1921

8. AGE: Years	Months	Days	If less than one day
18	1	23	---hrs. ---min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Unknown

FATHER
12. Name: Thomas Weems
13. Birthplace: Lutherville, Md.

MOTHER
14. Maiden name: Florence Taylor
15. Birthplace: St. Mary's Co., Md.

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. cremation (Burial, cremation, or removal. Which?) Date thereof Nov 21.1939 (month) (day) (year)

Cemetery or crematory: City Morgue

Location: Balto. Md.

19. Funeral director: S. T. Hemsley

Address: 518 W. Biddle St. Balto. Md

19. 11/13/39 (Date rec'd by registrar) 19 Albert R Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 13, 1939 at 2.30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan., 15, 1937 to Nov., 13, 1939 and that I last saw him alive on Nov., 13, 1939

Immediate cause of death: Pulmonary Tuberculosis — DURATION: July 1936

Due to: ---

Due to: ---

Other conditions: ---
(Include pregnancy within 3 months of death)

Major findings:
Of operations: ---

Of autopsy: ---

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work? ---

23. SIGNATURE: Reuben Hoffman M. D.
M. D. or other

Address: Henryton, Md. Date signed: 11/13/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 4 1939
BUREAU V. S.